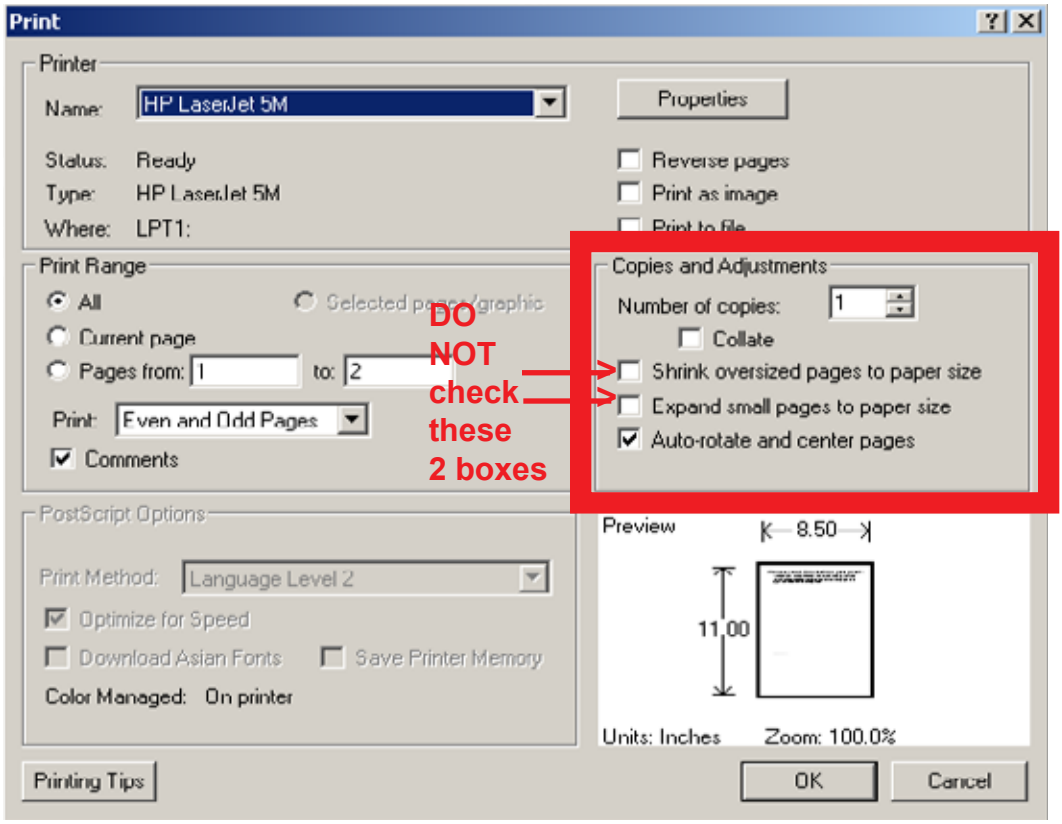
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



DOH 600-033 (4/2006)

(This page intentionally left blank.)

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Dental Hygiene Sealant/Fluoride Varnish Endorsement Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Dental Hygiene Sealant/Fluoride Varnish Endorsement

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 645-106 (REV 4/2006)

1F 0299090001 01977

(This page intentionally left blank.)

Instructions for Dental Hygiene Sealant/Fluoride Varnish Endorsement

All Applicants:

Please read all instructions thoroughly, complete the application in full. The Department of Health will not consider an application that is deficient of any documentation. If you need additional space to respond to a question, attach separate sheets, indexed to the appropriate questions, to the back of the application. To ensure appropriate review, all information should be typed or printed clearly. A resume **cannot** substitute for completion of the application.

1. **Demographic Information.** Please ensure that all information is up to date and complete. If you have had a name change, please enclose certified documents evidencing the change.
2. **Licensure Information.** Please indicate all health care licenses you hold or have held in Washington State. Be sure to include the original license issue date, the expiration date and method of licensure for each license held.
3. **Personal Data Questions.** If you answer "yes" to any of the Personal Data Questions, you must submit the additional supporting documentation for that question, as indicated on the application. A "yes" response will not necessarily result in application denial, however, failure to honestly respond could be grounds to deny an application. Where specific statutes are indicated, be sure to read the appropriate statute prior to answering the question.
4. **Training.** Provide proof of the completion of training as contained in the Washington State Department of Health sealant/fluoride varnish program guidelines.

Applicants for endorsement must obtain the training as contained in the Washington State Department of Health sealant/fluoride varnish program guidelines, which can be met through any one of the following methods:

a. Graduation from a dental assisting, dental hygiene or dental educational program, accredited by the American Dental Association, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

b. Continuing education courses which teach the Washington State Department of Health sealant/fluoride varnish program guidelines.

c. Individual training provided by a Washington licensed dentist, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

5. **Applicant's Attestation.** Complete and sign the attestation.

Application and Sealant/Fluoride Varnish Endorsement Fee ..... $50 **(This is a non-refundable fee.)**

Fees must be made payable to the Department of Health, in U.S. Funds. (Check or money orders please—no cash.)

Direct mail **with money** to:

Department of Health
Customer Service Center
PO Box 1099
Olympia, WA 98507-1099

Direct mail **without money** to:

Department of Health
Dental Hygiene Program
PO Box 47867
Olympia, WA 98504-7867

Direct Telephone Calls to:.....(360) 236-4700
FAX # .....(360) 664-9077
Website Address:.....www.doh.wa.gov

Important Notices

All application and licensure information is subject to public inspection and copying under Washington State Public Disclosure Law. Recent legislative changes allow applicants and licensees to request their residential address and residential telephone number be exempt from public disclosure. An alternative or business address and telephone number must be provided. A written request must be made to exempt your personal residence or telephone number.

Washington State Law and Department of Health Policy prohibit employees from receiving any gifts, gratuities and/or favors. Any offer of private benefit to an employee that is intended to influence a public decision is bribery and violates Federal and State Law.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
Certification #:	Date Issued:

Certification #

Application For Dental Hygiene Sealant / Fluoride Varnish Endorsement

Please Type or Print Clearly—Follow carefully all instructions provided in the general instructions. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department of Health will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW.) — —

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH (CITY/STATE)	MAIDEN NAME
☐ Female ☐ Male	/ /		

2. Previous Licensure

List all states where licenses are or were held. (Previous credential to include license, certification, or registration.) Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE/JURISDICTION	PROFESSION	CREDENTIAL		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR ISSUED	NUMBER		EXAMINATION	OTHER	
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Training Affidavit

Please have the applicable training provider sign and date the training method listed below to verify how you obtained the training contained in the Washington State Department of Health sealant/fluoride varnish program guidelines.

a. Graduation from a dental assisting, dental hygiene or dental educational program, accredited by the American Dental Association, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

SIGNATURE DATE

b. Continuing education courses which taught the Washington State Department of Health sealant/fluoride varnish program guidelines.

SIGNATURE DATE

c. Individual training provided by a Washington licensed dentist, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

SIGNATURE DATE

5. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center